Press release: Report 05/2017: Near miss between a train and a track worker at Shawford

RAIB has today released its report into a near miss between a train and a track worker at Shawford on 24 June 2016.

Summary

At 12:22 hrs on 24 June 2016, a train travelling at about 85 mph (137 km/h) narrowly missed striking a track worker near Shawford station, Hampshire. The track worker and a controller of site safety (COSS) had gone onto the railway to locate a reported rail defect. The track worker was not injured but was badly shaken by the incident. After making an emergency stop, the train driver reported the incident and was fit to continue his journey.

The immediate cause was that the track worker had become distracted while he was standing on a line on which trains were running. This happened because there was a breakdown in safety discipline and vigilance when the COSS and track worker went onto the railway. Firstly, they did not implement the required safe system of work for going onto the railway at Shawford. Secondly, the track worker crossed the railway without the permission of the COSS. Thirdly, the track worker was distracted and stopped on an open line when crossing back. The RAIB found a similar breakdown in safety discipline and vigilance when it investigated a fatal accident at Newark North Gate (report 01/2015). It is probable that the track worker's alertness and decision making were affected by fatigue, because he had slept in his car all week to avoid making long journeys to and from home each day. A possible underlying factor was that the rail testing and lubrication section within the Network Rail delivery unit involved was not resilient to any loss of resources or sudden increase in workload. Although not causal to the incident, the RAIB also observed that the way in which the section carried out safe system of work planning for its staff was not compliant with Network Rail's processes, and neither the COSS nor the track worker reported their involvement in the incident at the time.

Recommendations

In addition to a previous recommendation and learning point from the Newark North Gate accident, which also address the key issue of the breakdown in safety discipline and vigilance in this incident, the RAIB has made three new recommendations, addressed to Network Rail. The first relates to the management of fatigue for staff needing to make long journeys before and after a shift. The second relates to making the rail testing and lubrication section of the delivery unit more able to accommodate a short-term loss of resource and peaks in workload. The third recommendation calls for Network Rail to consider the reasons why its management arrangements on Wessex Route

did not detect and rectify the non-compliances with the processes for managing the safety of people working on or near the line. The investigation also identified six learning points about: reminding staff of the importance of following existing rules and procedures; how the early use of the train's horn by drivers to give an urgent warning can avert an accident if track workers on their line do not acknowledge the first horn warning; and the timely reporting of operational incidents.

Notes to editors

1. The sole purpose of RAIB investigations is to prevent future accidents and incidents and improve railway safety. RAIB does not establish blame, liability or carry out prosecutions.
2. RAIB operates, as far as possible, in an open and transparent manner. While our investigations are completely independent of the railway industry, we do maintain close liaison with railway companies and if we discover matters that may affect the safety of the railway, we make sure that information about them is circulated to the right people as soon as possible, and certainly long before publication of our final report.
3. For media enquiries, please call 01932 440015.

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